

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 24 1957

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BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>4413</u>		Registrar's No. <u>71</u>	
1. PLACE OF DEATH a. COUNTY <u>PIKE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FRANKFORD MO.</u>				c. LENGTH OF STAY (In this place) <u>53 yrs</u>		c. CITY OR TOWN <u>FRANKFORD</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
STREET ADDRESS <u>0820</u> (If rural, give location) <u>0</u>							
3. NAME OF DECEASED (Type or Print)		a. (First) <u>BLON</u>		b. (Middle) <u>MARIE</u>		c. (Last) <u>GREEN</u>	
4. DATE OF DEATH		(Month) <u>JUNE</u>		(Day) <u>3</u>		(Year) <u>1957</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>OCT. 19 1903</u>	
9. AGE (In years last birthday) <u>53</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>FRANKFORD MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ELLWOOD WILLIAM HUBERT</u>		13b. MOTHER'S MAIDEN NAME <u>FANNIE HUBERT</u>	
14. NAME OF HUSBAND OR WIFE <u>ERMA GREEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-28-1843</u>		17. INFORMANT'S SIGNATURE OR NAME <u>William Daniel Green City of Frankford, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>  ANTECEDENT CAUSES  Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH _____		19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>1 P</u> m., from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) <u>J. C. Mudd Coroner</u>	
23b. ADDRESS <u>Baniling Green Mo.</u>		23c. DATE SIGNED <u>June 3-57</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 6-1957</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM</u>		24d. LOCATION (City, town, or county) (State) <u>FRANKFORD MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernice Collier</u>		ADDRESS <u>Frankford Mo.</u>	
DATE REC'D BY LOCAL REG <u>June 11, 1957</u>		REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. ...</u>		ADDRESS <u>Frankford Mo.</u>	
(Licensed Embalmer's Statement on Reverse Side)							

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Jane Fields Megaw*

Licensed Embalmer No. *4093*

P. O. Address *Frankfort*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.